FOR OFFICE USE ONLY

REG NUMBER: _____

DATE: _____

KANSAS STATE BOARD OF PHARMACY
800 SW JACKSON, ROOM 1414
TOPEKA, KS 66612
(785) 296-4056
FAX (785) 296-8420

FEE $300.00

APPLICATION FOR MANUFACTURER REGISTRATION

This application is being made for the following reason: (check all that apply):

_____New _____Change of Address _____Change of Ownership _____Change of PIC

Previous Kansas License Number (if applicable)_____

The owner hereby makes application as follows:

_____
BUSINESS NAME OF OWNER

_____
ADDRESS OF OWNER

_____
CITY STATE ZIP PHONE NUMBER

_____
E-MAIL ADDRESS

Type of ownership is: _____Individual _____Partnership _____ Corporation _____Other

IF PARTNERSHIP, attach additional listing of names and percentage of ownership.
IF CORPORATION, attach additional listing of officer and owners of stock.
IF OTHER, attach additional sheet indicating the type of ownership

The owner makes application for registration to manufacture drugs and/or controlled substances in the State of Kansas under the name of and at the following location?

_____
NAME OF BUSINESS/FACILITY

_____
PHYSICAL ADDRESS OF MANUFACTURING FACILITY

_____
CITY STATE ZIP PHONE NUMBER

_____
E-MAIL ADDRESS

_____
CONTACT PERSON/AUTHORIZED REPRESENTATIVE TITLE PHONE

_____

MAILING ADDRESS FOR RENEWAL INFORMATION IF DIFFERENT THAN PHYSICAL ADDRESS

_____

CITY STATE ZIP

Drug Schedules **(Check all that apply)**

_____Legend Drugs _____Controlled Substances _____Nonprescription Drugs

_____Schedule I _____Schedule II/nonnarcotic _____Schedule II/narcotic

_____Schedule III/nonnarcotic _____Schedule III/narcotic _____Schedule IV

_____Schedule V

Is applicant registered by DEA to dispense controlled substances in the schedules for which you are applying? Yes_____ No_____

If Yes, please enclose a copy of the DEA certificate.

If no, has application been made and pending? Yes_____ No_____

Has the applicant been convicted of any violation of State or Federal Law relating to controlled substances? Yes_____ No_____

If yes, was conviction a felony? Yes_____ No_____ **Attach additional sheet explaining in detail.**

Has any previous registration held by the applicant under any name or corporate or legal entity under the Kansas Uniform Controlled Substance Act been surrendered, revoked, suspended, denied or is it pending such action? Yes_____ No_____

If yes, attach a letter setting forth the circumstances of such action.

Is the applicant presently registered with the Food and Drug Administration (FDA)? Yes_____ No_____

If yes, state the present FDA registration number and expiration date:

_____

The owner and/or responsible pharmacist understand the registration, if issued, will expire annually on the 30th day of June and such registration will be cancelled if not renewed annually by the 31st day of July.

OWNER/CORPORATE OFFICER PORTION

I, _____, being the owner or agent of the owner of the manufacturer indicated on this application, do solemnly swear (or affirm) that, if a registration be issued as requested, such manufacturer will be conducted and operated in full compliance with the Pharmacy Act and the Controlled Substance Act of the State of Kansas and all other laws of Kansas so long as continued under such registration and that the registration will expire ANNUALLY on JUNE 30TH and such registration will be canceled if not renewed ANNUALLY by July 31ST.

I further solemnly swear (or affirm) that the statements and representations made in the foregoing application are true and correct.

_____
SIGNATURE OF OWNER OR AGENT OF OWNER

Signed and sworn to (or affirmed) before me on _____day of _____, 20_____.

(Seal)

My commission expires _____ _____
SIGNATURE OF NOTARY PUBLIC

AUTHORIZED AGENT/CONTACT PORTION

I, _____, being the AUTHORIZED AGENT of the manufacturer indicated on this application, do solemnly swear (or affirm) that I understand that if such registration is issued, it will be issued jointly to the owner and myself and, in the event that I shall no longer be authorized agent of such manufacturer, I shall notify the Executive Secretary of the Board of Pharmacy of Kansas and forward such registration to the Executive Secretary.

I further swear (or affirm) that I understand all my responsibilities to the Board of Pharmacy of Kansas as Authorized agent of such manufacturer and that I will comply with the Pharmacy Act and the Controlled Substances Act of the State of Kansas and all other laws of Kansas and that the registration will expire ANNUALLY on JUNE 30TH and such registration will be canceled if not renewed ANNUALLY by JULY 31ST.

_____
SIGNATURE OF AUTHORIZED AGENT

Signed and sworn to (or affirmed) before me on _____day of _____, 20_____.

(Seal)

My commission expires _____ _____
SIGNATURE OF NOTARY PUBLIC

NOTE: Signatures are required for the owner and the authorized agent. If the owner and authorized agent are the same individual, both portions must be signed and notarized.